DINA Dental Plan™
Guaranty Assurance Company
11969 Bricksome Avenue, Ste A
Baton Rouge, LA 70816

DINA Dental Plan™
Customer Service: (866) 436-3093
Marketing: (800) 376-3462 or (225) 291-3172
Marketing Fax: (225) 292-3075

Agent Information Packet

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Agent Sales & Marketing Contacts: (800) 376-3462 or (225) 291-3172

Loralyn Chenevert x1401 ~ Sales & Marketing Assistant, Group Sales, Agent Support, Account Manager
Doug Jones x1403 ~ Director of Sales & Marketing

www.dinadental.com

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General Underwriting

Passive PPO & Full Indemnity Plan

1. Minimum enrollment requirements:
   - Five lives per groups without ortho
   - Ten lives per groups that want to include the ortho option
2. Completely voluntary
3. Each group has the option to customize their plan benefits
4. Cannot be offered to individuals
5. See any dentist – no network restrictions – all claims paid at the 90th percentile
6. Low plan option can be offered as a "Dual Choice" on groups of 50+
7. Premium rates are guaranteed for a period of at least one (1) year. Large groups may request to be considered for a two (2) year rate guarantee.
8. To obtain a quote use Group Quote Request Form (Page 16)
9. May be offered as Passive PPO using Dentemax Network
10. Existing rates and loss ratio data (2 years) needed on groups over 100

PPO Plan

1. Available to groups and individuals – Two (2) lives are needed to be considered a group
2. Completely voluntary – no participation requirements
3. Claims are paid from a set fee schedule
4. See any dentist or use a DINA Dental PPO Plan Network Provider
5. Members may incur a higher out-of-pocket cost when using a provider who is not in our network
6. Can be offered as a "Dual Choice" with other DINA plans
7. No quote required – shelf rates
8. Individuals must pay for 6 or 12 months (option to pay monthly by bank draft or credit card)

Prepaid Plan

1. Available to groups and individuals – Two (2) lives needed to be considered a group
2. Completely voluntary – no participation requirements
3. No claim forms – no deductibles – no maximums – no waiting periods
4. Member MUST use a provider who participates in the DINA Dental Prepaid Plan Network
5. Can be offered as a "Dual Choice" with other DINA plans
6. No quote required – shelf rates
7. Individuals must pay for 6 or 12 months (option to pay monthly by bank draft or credit card)

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Application Submission Procedures

All Applications whether group or individual will have an effective date of the **first of each month**

To submit a NEW GROUP, the following materials for this packet should be DINA's Baton Rouge office by the **25th day of the month prior to the effective month** before it will be effective. Contact DINA if applications will be submitted after the 25th.

1. Group Application (see Page 17 for form)
2. Individual Applications (see Page 18-20 for applicable forms)
3. Takeover Proof (Usually the most recent bill showing all eligible members for continuous coverage)
4. Binder Check (1st Month's Premiums)
5. Signed Single Case Commission Agreement (see Page 21 for form)

All new group packets are processed in our office in Baton Rouge, LA.

Mail the new group packet to:*
DINA Dental
Attn: Loralyn Chenevert
11969 Bricksome Ave, Ste A
Baton Rouge, LA 70816

***Once the group is established, any and all adds, changes, deletes, etc. are to be faxed to Benefits Administration Department @ 832-415-0131 or emailed dina@fcldental.com . The group can use the change form (see Page 24 for form) or their customized employee application to submit changes.

To submit a NEW INDIVIDUAL APPLICATION the following materials for this packet should be DINA's Baton Rouge office by the **25th day of the month prior to the effective month** before it will be effective. **Whether Prepaid or PPO the following forms must be submitted**:

1. Individual Application (see Page 18-19 for forms)
2. For monthly payments use either:
   Bank Draft Form – Be sure to include a voided check (see Page 23 for form)
   ~or~
   Credit Card Draft Form (see Page 22 for form)
3. For payment 6 or 12 months in advance include a check in that amount of premium.

All individual packets are processed in our home office in Sugar Land, TX

Mail the individual application packet to:
DINA Dental
Guaranty Assurance Company
PO Box 654303
Dallas, TX 75265-4303

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Passive PPO or Full Indemnity Dental Plan (100/80/50/50)

Choice of Annual Benefit (Per Person). . . . $1,000 - $1,500 - $2,000 - $2,500

Percentage of Covered Benefits per Policy Year

	TYPE I	TYPE II	TYPE III*	ORTHO
CO-INSURANCE	100%	80%	50%	50%

Calendar Year Deductible (Per Person) $50 / $150 (Optional Higher Deductibles)

This deductible applies to Type II and III services

Payment is based upon allowable charges in the area in which service is rendered.
Services provided at a non-contracting provider are paid at the 90th percentile.

Late Entrant Provision

If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholder's next annual election period, they will become a Late Entrant. Late Entrant benefits will be limited to preventive and basic procedures only for the first 12 months of coverage. Late Entrants will have a 12 month wait for Type III and Ortho benefits.

TYPE I (PREVENTIVE SERVICES)

Including:

- No waiting period, no deductible
- Routine Exams
- Prophylaxis (cleanings-one per 6 months)
- Emergency exams for dental pain (minor procedures)
- Fluoride treatments for dependent children under age 19 (one per 12 months)
- Bitewing X-rays (once per 6 months)

TYPE II (BASIC SERVICES)

Including:

- No waiting period
- Full mouth or panorex X-rays (1 per 36 months)
- Simple restorative services (fillings)
- Simple extractions
- Sealants for children ages 6-15 (1 per tooth)

TYPE III (MAJOR SERVICES)

Including:

- 12 month waiting period (option to waive)
- Major restorative services (crowns and inlays)
- Prosthetics (bridges, dentures)
- Replacement of prosthodontics, dentures, crowns and inlays
- Denture relines
- Space maintainers
- Oral Surgery
- General anesthesia (for services dentally necessary)
- Endodontics/root canal therapy (Option to move to Type II)
- Periodontics (Option to move to Type II)

ORTHODONTIC SERVICES - OPTIONAL

- 12 month waiting period (option to waive)
- $50 separate deductible (option to waive)
- 50% coverage for children only up to age 19
- Choice of lifetime maximum benefits
  $1,000 ~ $1,500 ~ $2,000

See Any Dentist ~ No Network

2 Tier Rating Structure
Employee Only
Employee + Family

3 Tier Rating Structure
Employee Only
Employee + One
Employee + Family

4 Tier Rating Structure
Employee Only
Employee + Spouse
Employee + Child (ren)
Employee + Family

Quote Request
E-mail, Call, or Fax Quote Request
loralyn@dinadental.com
or doug@dinadental.com
Phone (225) 291-3172
or (800) 376-3462
Fax (225) 292-3075

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Passive PPO/Full Indemnity Low Dual Option Dental Plan (80/50)

Annual Benefit - Per Person $750

Percentage of Covered Benefits per Policy Year

	TYPE I	TYPE II	TYPE III*	ORTHO
CO-INSURANCE	**80%**	**50%**	**N/A**	**N/A**

Calendar Year Deductible, Per Person $50 / $150
This deductible applies to Type II services

Payment is based upon allowable charges in the area in which service is rendered.
Services provided at a non-contracting provider are paid at the 90th percentile.

Late Entrant Provision

If an employee or dependent does not elect to participate when initially eligible, and elects to participate at the policyholder's next annual election period, they will become a Late Entrant. Late Entrant benefits will be limited to preventive and basic procedures only for the first 12 months of coverage.

TYPE A (PREVENTIVE SERVICES)
Including:
- No waiting period, no deductible
- Routine Exams
- Prophylaxis (cleanings-one per 6 months)
- Emergency exams for dental pain (minor procedures)
- Fluoride treatments for dependent children under age 19 (one per 12 months)
- Bitewing X-rays (once per 6 months)

TYPE B (BASIC SERVICES)
Including:
- 12 month waiting period applies to Endodontics and Periodontics benefits only
- Full mouth or panorex X-rays (1 per 36 months)
- Simple restorative services (fillings)
- Simple extractions
- Sealants for children ages 6-15 (1 per tooth)
- Endodontics/root canal therapy
- Periodontics

See Any Dentist ~ No Network

Offer this plan to large groups as a Dual Option with the Higher Indemnity Plan.

2 Tier Rating Structure
Employee Only
Employee + Family

3 Tier Rating Structure
Employee Only
Employee + One
Employee + Family

4 Tier Rating Structure
Employee Only
Employee + Spouse
Employee + Child (ren)
Employee + Family

Quote Request
E-mail, Call, or Fax Quote Request
Loralyn@dinadental.com
or doug@dinadental.com
Phone (225) 291-3172
or (800) 376-3462
Fax (225) 292-3075

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Limitations and Exclusions on All Full Indemnity Plans

Covered Expenses Will Not Include and No Benefits Will Be Payable:

1. For major services in the first 12 months that the Insured is covered, except as may be provided in the Takeover Benefits provision.
2. For any treatment which is for cosmetic purposes or to correct congenital malformations, except for medically necessary care and treatment of congenital cleft lip and palate.
3. To replace any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement of these items, unless required because of an accidental bodily injury sustained while the Insured is covered. Replacement is not covered if the item can be repaired.
4. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of natural teeth during the same period of continuous coverage. But the extraction of a third molar (wisdom tooth) will not qualify the item for payment. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth. Coverage does not include the part of the cost that applies specifically to replacement of teeth extracted prior to the period of coverage.
5. For addition of teeth to an existing prosthetic appliance or fixed bridge unless for replacement of natural teeth extracted during the same period of continuous coverage.
6. For any expense incurred or procedure begun before the Insured's current period of continuous coverage.
7. For any expense incurred or procedure begun after the Insured's insurance under this section terminates, except for a prosthetic appliance, fixed bridge, crown, or inlay or onlay restoration for which both (a) the procedure begins before insurance ends and (b) the item's final placement is within 90 days after insurance ends.
8. To duplicate appliances or replace lost or stolen appliances.
9. For appliances, restorations or procedures to:
   a. alter vertical dimension;
   b. restore or maintain occlusion;
   c. splint or replace tooth structure lost as a result of abrasion or attrition; or
   d. treat jaw fractures or disturbances of the temporomandibular joint.
10. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.
11. For broken appointments or the completion of claim forms.
12. For orthodontia service or for any services associated with orthodontic therapy when this optional coverage is not elected and the premium is not paid.
13. For sealants which are:
    a. not applied to a permanent molar;
    b. applied before age 6 or after attaining age 16; or
    c. reapplied to a molar within three years from the date of a previous sealant application.
14. For subgingival curettage or root planning (procedure numbers 4220 and 4341) unless the presence of periodontal disease is confirmed by both x-rays and pocket depth summaries of each tooth involved.
15. Because of an Insured's injury arising out of, or in the course of, work for wage or profit.
16. For an Insured's sickness, injury or condition for which he or she is eligible for benefits under any Workers Compensation Act or similar laws.
17. For charges for which the Insured is not liable or which would not have been made had no insurance been in force.
18. For services which are not recommended by a dentist, not required for necessary care and treatment, or do not have a reasonably favorable prognosis.
19. Because of war or any act of war, declared or not, or while on full-time active duty in the armed forces of any country.
20. To an Insured if payment is not legal where the Insured is living when expenses are incurred.
21. For any services related to: equilibration, bite registration or bite analysis.
22. For crowns for the purpose of periodontal splinting.
23. For charges for: any implants; overdentures; precision or semi-precision attachments and associated endodontic treatment; other customized attachments; or specialized prosthodontic techniques or characterizations.
24. For charges for myofunctional therapy, orthognathic surgery or athletic mouthguards.
25. For procedures for which benefits are payable under the employer's medical expense benefits plan for employees and their dependents.
26. Services or supplies provided by a family member or a member of the Insured's household.

Note: This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. See your certificate for details.

Predetermination of Benefits for All Full Indemnity Plans

As a service to protect the Insured, Guaranty Insurance Company will provide predetermination of benefits for recommended treatment plans that exceed $300. This predetermination of benefits explains which of the recommended procedures will be covered and at what amount. This benefit helps Insured's better understand their coverage. The Insured should submit the treatment plan to Guaranty Insurance Company for review and predetermination of benefits before the service begins.

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PPO Plan ~ Highlights & Benefits

Use Any Dentist or a DINA PPO Dentist – Available to Individuals or Groups

Our DINA panel of providers are contracted, credentialed, and have agreed to charge predetermined fees for procedures.

Co-payments not to exceed certain discounted dollar amounts.

*Usual, Reasonable and Customary charges may apply when accessing a dentist who is not participating in the network.

Immediate Coverage for Type I and Type II ~ Benefit Year Maximum Increases to $1500 (3rd Benefit Year)

Discount on Orthodontics ~ Qualifies for Section 125 (Cafeteria Plan) Deductions

Monthly Premiums

Individual or Employee Only	**$20.00**
Individual or Employee + One	**$38.00**
Individual or Employee + Family	**$60.00**

Benefit Year Maximum	**First Year**	**Second Year**	**Thereafter**
Per Covered Person	$750	$1,000	$1,500

Insurance Percentage	**First Year**	**Second Year**	**Thereafter**
Type I Covered Expenses	100%	100%	100%
Type II Covered Expenses	80%	80%	80%
Type III Covered Expenses	0%	50%	50%

Waiting Period	**First Year**	**Second Year**	**Thereafter**
Type III Covered Expenses	12 months (Unless Takeover)	None	None

Benefit Year Deductible	**First Year**	**Second Year**	**Thereafter**
Type I Covered Expenses per Covered Person	$50	None	None
*Type II Covered Expenses per Covered Person	$50	$50	$50
*Type III Covered Expenses per Covered Person	No Benefits	$50	$50
Family Maximum Deductible per Year	$150	$150	$150

*One $50 to be met with either Type II or Type III or a combination of both.

Orthodontics	**Benefits**
(Participating Orthodontists ONLY)	Initial Consultation Covered at 100%
	Treatment Covered at 20% Discount

Types of Service	**Description of Covered Services**
Type I - Preventative & Diagnostic	Exams, Evaluations, Cleanings, X-rays, Fluoride Treatments, Sealants
Type II - Basic Services	Fillings, Extractions
Type III - Major Services	Crowns, Root Canals, Periodontal Scaling, Partials, Dentures, Oral Surgery

IMPORTANT NOTICE: These benefits are payable when using one of our Preferred Providers. If you choose another provider that does not participate with DINA Dental, you may incur additional charges. The Scheduled Charge is the maximum amount which benefits will be paid. A non-participating provider may charge more than the Scheduled Charge. If your dentist charges more than the Scheduled Charge, you will pay the deductible and co-insurance plus the amount over the Scheduled Charge.

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Specialist Services

- Members may seek the services of a Specialist as a part of their plan. DINA has contracted with Specialists in the service areas. A listing of the Specialists may be viewed from our website at www.dinadental.com , or by contacting Customer Service at 866-436-3093.

- If a member visits an in-network Specialist, that Specialist will discount their usual and customary fees by 10% to 20% to the member. You should ask the Specialist what that discount would be. DINA will then pay the Specialist the amount listed in the feed schedule (part of the policy) for the benefit. The member will be responsible for the difference between the Specialist usual and customary charge, less the discount and the amount DINA pays for that benefit.

- If a member visits an out-of-network Specialist, DINA will pay the amount listed in the fee schedule for that benefit. That Specialist has not been contracted by DINA and is under no obligation to discount their fee. The member will be responsible for the difference between the Specialist usual and customary fee and the amount DINA pays according to the fee schedule.

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Prepaid Plan ~ Highlights & Benefits

**** NO Claim Forms * NO Deductibles * NO Maximums * No Waiting Periods ****

Some Preventive and Diagnostic Services ~ Provided at NO CHARGE

Over 180 Procedures Covered by Co-Payments ~ Qualifies for Section 125 (Cafeteria Plan) Deductions

Must Select Dentist from Dina Network of Dentists ~ Network Includes Dentists Across the State of Louisiana

Individual Monthly Rates	
Individual Only	$13.00
Individual + 1	$21.00
Individual + 2 or 3	$28.00
Individual + 4 or More	$32.00

Available to Individuals or Groups
Must Use Network Provider

Group Monthly Rates	
Employee Only	$13.00
Employee + 1	$21.00
Employee + Family	$28.00

Diagnostic Procedures	Co-payment
Comprehensive oral exam	$47.00
Limited oral evaluation – problem focused	$33.00
Periodic exam – once every 6 months	$27.00
X-ray – intraoral – periapical - first film – once every 6 months	$15.00
X-ray – intraoral – occlusal – once every 6 months	$21.00
X-ray – extraoral – first film – once every 6 months	$15.00
X-ray – bitewing – 2 films – once every 6 months	$22.00
X-ray – intraoral – complete series – once every 36 months	$59.00
Diagnostic casts	$47.00
Preventative Procedures	**Co-payment**
Routine teeth cleaning – adult – once every 6 months	$48.00
Routine teeth cleaning – child – once every 6 months	$35.00
Fluoride treatment – child – once every 12 months	$20.00
Sealant – each tooth – once every 36 months	$26.00
Restorative Procedures	**Co-payment**
Amalgam filling – 1 surface – primary (baby) tooth	$ 64.00
Amalgam filling – 2 surface – primary (baby) tooth	$ 81.00
Amalgam filling – 3 surface – permanent tooth	$98.00
Resin filling – 1 surface – anterior (front tooth)	$75.00
Resin filling – 2 surface – anterior (front tooth)	$93.00
Resin filling – 3 surface – anterior (front tooth)	$115.00
Crown – porcelain-fused to predominately based metal	$525.00
Crown – porcelain-fused to high noble metal	$567.00
Crown – full cast – predominately based metal	$440.00
Core buildup – including any pins	$127.00
Temporary crown (fractured tooth)	$75.00
Root canal – Anterior (front tooth)	$350.00
Periodontal scaling and root planning-per quadrant	$ 96.00
Full mouth debridement for comprehensive periodontal evaluation	$ 86.00
Denture – complete upper or lower	$600.00
Immediate denture – upper or lower	$525.00
Upper partial – resin base – complete	$471.00
Add tooth to existing partial denture	$ 83.00
Extraction – single tooth	$ 64.00
Removal of impacted tooth – soft tissue	$150.00
Incision and drainage of abscess – intraoral soft tissue	$09.00

This is only a summary of over 180 dental services included in the plan (participating dentist must be used).

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Takeover Benefits

Takeover means that you are given credit for waiting periods for like coverage's accumulated under your existing plan. No credit is given for deductibles satisfied under your existing plan.

- In order to provide Takeover Benefits your employer's current dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan with no lapse in coverage.
- All employees insured on the effective date with continuous coverage from the prior group dental contract are eligible for Takeover Benefits. Waiting periods will be reduced by the amount of time insured under the prior plan.
- Takeover Benefits must be requested and are subject to the approval of Guaranty Assurance Company.

Claim Processing (Does NOT Apply to the Prepaid Plan)

- Average turnaround for payment of claims is 2 weeks provided the claim submission has no errors or missing information. Most claims are paid within 30 days.
- Claims can be submitted electronically, mailed, or faxed to the following:

Electronic Filing Information:

Payor ID: CX090

Website: www.emdeon.com

Mailing Address and Fax # for Claims:

DINA Dental Plan
101 Parklane Blvd, Ste 301
Sugarland, TX 77478

Fax Number (281) 313-7155

Enrollment Guidelines

- Groups will be allowed to enroll via electronic transfer.
- Groups can also enroll via spreadsheets (for large groups) or applications.
- All electronic enrollments, transfers, and paper applications need to be received in our office within 2 to 4 weeks prior to the effective date. This is to allow enough time for all policies and identification cards to be process and mailed to the members.

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References: Louisiana 2014

Account Name: **St. Landry Parish School Board**
Address: PO Box 310, Opelousas, LA 70571
Contact: Janice Sam
Phone: 337-948-3657
Business Type: University – Education
Account Size: 925 Members

Account Name: **State of Louisiana**
Address: PO Box 94095, Baton Rouge, LA 70804
Contact: Jena W. Cary or Angel Vernon
Phone: 225-342-0713
Business Type: State Government
Account Size: 1,975 Members

Account Name: **Lafayette Parish School Board**
Address: PO Drawer 2158, Lafayette, LA 70502
Contact Name: Cindy Wilkinson
Phone: 337-521-7064
Business Type: School Board – Education
Account Size: 1,101 Members

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Added Benefits for DINA Dental Members

Free Discounted Vision Plan

As a member of DINA, you and your family have access to a **Free** Discount Vision Plan.

You can view the benefits and print a card by visiting our website, www.dinadental.com and click on the "**Links"** tab which will direct you to the U.S. Vision Plan website. Also, you can go directly to www.usvisionplan.com and print your card.

This card is pre-activated and can be used immediately. It is a free service offered by DINA Dental and is not an insurance product.

Free Prescription Drug Card

Visit www.dinadental.com or www.unarxcard.com to download and print a card that offers a savings of 30% to 70% on your prescription drugs. This card is recognized at over 50,000 pharmacies.

This card is also pre-activated and can be used immediately. It is a free service offered by DINA Dental and is not an insurance product.

FREE Vision Discount Plan with the purchase of any DINA Dental Plan™

As a member of DINA, you and your family have access to a **Free** Discount Vision Plan.

You can view the benefits and print a card by visiting our website, www.dinadental.com and click on the "**Links"** tab which will direct you to the U.S. Vision Plan website. Also, you can go directly to www.usvisionplan.com and print your card. This card is pre-activated and can be used immediately.

This is a free service offered by DINA Dental and is not an insurance product.

A member of:
United Networks
OF AMERICA

A member of:
United Networks
OF AMERICA

Member Benefits

$25 Eyeglasses "New"

Eye Exams	5% to 20% Discount
Frames	20% to 50% off retail
Lenses	20% to 25% off retail
LASIK	15% to 55% discount
CRT procedure	20% to 25% discount
Online Contact Lenses	Best Price Guarantee

Note: Fees vary by vendor and vendor location. The deepest discounts can be found at Target Optical, JC Penny Optical, Pearle Vision Centers, and Sears Optical.

USVISIONPLAN.COM is a Discount *Preferred Provider Network* (DPPN) NOT insurance.

Designed & Maintained by NetShapers, Inc.

Pearle Vision · EyeMasters Why pay more? · Cohen's Fashion Optical · Target Optical
Visionworks Why pay more? · ShopKo · Site for Sore Eyes · Empire Vision Centers Focused on You
D.O.C Leaders in eyecare · Vision World Why pay more? · it's all inside: JCPenney optical · Hour Eyes Doctors of Optometry
Sterling Optical · Sears Optical · VAL-U vision · TSO Texas State Optical

Frequently Asked Questions

Q: What is USVISIONPLAN.COM?

A: ***USVISIONPLAN.COM*** is a Discount *Preferred Provider Network* (DPPN). Unlike vision insurance our plan has no waiting periods, no limitations or exclusions, no annual/lifetime maximums, and no claim forms. Simply visit a ***USVISIONPLAN.COM*** Provider, show your member card, and pay the adjusted bill. ***USVISIONPLAN.COM*** is your simple solution to vision benefits!

Q: Do I need to get authorization to access this program?

A: No, if you are a member of ***USVISIONPLAN.COM*** you may visit any of our participating provider locations at any time. Please verify benefits with provider prior to any services being rendered.

Q: Are pre-existing conditions covered?

A: Yes, all pre-existing conditions are covered.

Q: What is the waiting period, deductible, etc.?

A: There is no waiting period before you can start using the plan! And, there are no deductibles, no claim forms to fill out, and no limits on visits to ***USVISIONPLAN.COM*** providers!

Q: How much do members save on vision fees?

A: Members can save up to 60% on vision products and services. You can view savings by visiting MEMBER BENEFITS.

Q: How do I know if I am a member of USVISIONPLAN.COM?

A: You should have a ***USVISIONPLAN.COM*** or United Networks of America logo on your member card. If you are not sure you can contact us at 800.726.4232.

Q: How do I access the Preferred Provider Listing?

A: The Preferred Provider Listing is accessible 24 hours a day on this web site. Simply enter your zip code and our search engine will display all ***USVISIONPLAN.COM*** providers located in your area.

Q: How do I know which Preferred Provider to select?

A: You may go to any provider listed on the ***USVISIONPLAN.COM*** Preferred Provider Network.

LASIK INFORMATION

QualSight℠
Preferred LASIK Pricing

Laser Vision Correction Program

As a US vision Plan member, you and members of your family may now receive significant savings on LASIK eye surgery!

Member Benefits:

1. Safe and Proven Technology – The latest FDA approved lasers
2. Experienced – Over 1.5 million procedures performed
3. Convenience – Over 600 locations nationwide
4. URAC/NCQA Credentialed LASIK Surgeons
5. Most Patients return to work the next day!
6. Retreatment Plans – Lifetime Assurance Plans available
7. Flexible Financing Options

How it Works:

1. Call 1-888-733-6695 to speak with a QualSight Care Manager
2. You must have your plan name and plan number to obtain preferred pricing (use your US VISION PLAN card).
3. A preliminary phone screening is conducted to ensure you are a potential candidate.
4. Select a provider from the list of credentialed, Board Certified Ophthalmologists in your area.
5. The Care Manager schedules your appointment and sends a pricing confirmation email/letter.

"More than 1/3 of Americans that use corrective eyewear are considering having LASIK to improve or correct their vision"
--- Vision Council of America

FREE Prescription Drug Card with the purchase of any DINA Dental Plan™

- Visit www.dinadental.com or www.unarxcard.com to download and print a card that offers a savings of 30% to 70% on your prescription drugs.
- This card is recognized at over 50,000 pharmacies.
- This card is also pre-activated and can be used immediately.
- This is a free service offered by DINA Dental and is not an insurance product.

UNA Rx Card

UNA RX CARD is a "**FREE**" discount prescription drug card delivered through a joint effort by RESTAT and United Networks of America. This program is made possible through the participation of U.S. pharmacies and pharmaceutical companies. UNA Rx Card provides members with average savings of 32%-35% off U&C Pricing with savings as high as 75% on some medications. UNA Rx Card is designed as a standalone benefit program but it may also be used as a supplement for insured prescription plans to cover non-formulary prescriptions. It can also be used as a Medicare Part D supplement by covering drugs once participants reach the "donut hole"!

The UNA Rx Card network includes most major pharmacy chains nationwide.

Here is a partial list of participating UNA Rx Card pharmacies:

DINA DENTAL PLAN

We have a plan to fit every smile.

Quote Request

Broker Information

Agency Name ~			Date of Request ~
Name of Agent Requesting Quote ~			
Address ~	City:	State:	Zip:
E-mail Address ~			
Phone Number ~ ( ) - Ext.		Fax Number ~ ( ) -	

Prospect Information

Name of Group ~			
Address ~	City:	State:	Zip:
Type of Business ~		Total Number of Employees ~ (*Include copy of current census if available*)	
Employer Contribution? Yes ☐ No ☐		If yes, percentage amount ~	
Is this a Takeover? Yes ☐ No ☐		If yes ~ 2nd ☐ or 3rd ☐	

3 Tier Rating

Enrollment Status	Current Rates	Renewal Rates
Employee Only	$	$
Employee + One	$	$
Employee + Family	$	$

4 Tier Rating

Enrollment Status	Current Rates	Renewal Rates
Employee Only	$	$
Employee + Spouse	$	$
Employee + Child(ren)	$	$
Employee + Family	$	$

Desired Effective Date ~	Date Quote Needed ~

Choose Plan/Plans for Quote ~ Passive PPO ☐ Full Indemnity ☐ PPO ☐ Prepaid ☐

The following information is needed to quote the **Passive PPO** or **Full Indemnity** Plan:

Deductible Amount ~ $50 ☐ $75 ☐ $100 ☐

Calendar Year Maximum Benefits ~ $1000 ☐ $1500 ☐ $2000 ☐

Include Orthodontic Rider ~ Yes ☐ No ☐ Lifetime Max for Ortho ~ $1000 ☐ $1500 ☐ $2000 ☐

Move Endo and Perio to Basic Services ~ Yes ☐ No ☐

Remove 1 Year Wait on Major Services ~ Yes ☐ No ☐

Comments or special requests:

Please e-mail or fax request to: loralyn@dinadental.com ~ Fax: 225-292-3075

DINA Dental
11969 Bricksome Ave, Ste A
Baton Rouge, LA 70816

225-291-3172 or 800-376-DINA (3462)
x1403 Doug Jones
x1401 Loralyn Chenevert

Doug@dinadental.com
Loralyn@dinadental.com

DINA Dental Plan™
Guaranty Assurance Company
11969 Bricksome Ave, Ste A
Baton Rouge, LA 70816

DINA Dental Plan™
Marketing: 225-291-3172
~ or ~ 800-376-3462
Fax: 225-292-3075

Group Application for Dental Policy

☐ **Checking this box designates the Policies & ID's to be mailed to individuals. If this box is not checked, the Policies & ID's will be mailed to the group address listed below.**

(Plan Sponsor ~ Employer) _____ (Effective Date) _____

(Mailing Address) _____ (City) _____ (State) _____ (Zip Code) _____

(Telephone Number ~ Include Area Code) _____ (Contact Person) _____

(Fax # ~ Include Area Code) _____ (E-mail Address) _____ (Number of Eligible Members in Group) _____

Does the Group have a Cafeteria Plan? Yes ☐ No ☐ (Anniversary Month of Group's Plan Year) _____

Group Plan Type (Select Only One)

Passive PPO Plan ☐ Indemnity Plan ☐ PPO Plan ☐ Prepaid Plan ☐

1. All eligible persons who are members of the group prior to the requested date of issue shall be eligible for coverage under the group policy as of the date of issue.
2. All eligible persons who become members of the group after the first day of the group's plan year shall be eligible for coverage on the first day of the month which will follow the completion of the number of continuous days of employment required by the plan's sponsor.

Coverage under this Group Policy will be offered to (Choose only 1): Employee Only ☐ Employee & Dependents ☐

Sponsor will contribute _____ % of the premium for (Choose only 1): Employee Only ☐ Employee & Dependents ☐

Sponsor will contribute _____ % of the premium for (Choose only 1): Employee Only ☐ Employee & Dependents ☐

Premiums will be paid by the plan sponsor in advance of each covered period. **Choose only one option:**

Monthly ☐ Quarterly ☐ Semi-Annually ☐

No agent has the authority to modify, enlarge, vary or waive any provision of the group policy which Guaranty Assurance Company will issue in connection with this application. It is agreed that Guaranty Assurance Company shall promptly refund any premium paid with this application if the group's policy is not issued for any reason or if it is returned within ten (10) days of receipt by the plan sponsor. Checks payable to DINA Dental Plan.

Application executed at _____ (Location of Office) this _____ (Day) day of _____ (Month) 20 _____ (Year)

_____ (Group Sponsor's Signature) _____ (Title)

Please Note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to a fine and confinement in prison.

_____ (Agent's Signature) _____ (Agent Number)

Application accepted by: _____ (Guaranty Officer's Signature) _____ (Date Signed)

Group Number: _____ Premiums: ____/____/____/____

Group Number: _____ Premiums: ____/____/____/____

DINA Dental Plan™
Guaranty Assurance Company
11969 Bricksome Ave, Ste A
Baton Rouge, LA 70816

DINA Dental Plan™
Marketing: 225-291-3172
~ or ~ 800-376-3462
Fax: 225-292-3075

☐Passive PPO or ☐Indemnity Plan

Employee Application for Membership & Dental Insurance

Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip:
Phone:	SSN:	Date of Birth: Male ☐ Female ☐
Employer:	Work Phone:	
Date of Hire:	Date of Termination (if cancelling):	

Effective Date Requested: (Must be 1st of Month)

2 Tier Rating		Premium
E Only	☐	$
E + Family	☐	$

3 Tier Rating		Premium
E Only	☐	$
E + One	☐	$
E + Family	☐	$

4 Tier Rating		Premium
E Only	☐	$
E + Spouse	☐	$
E + Child/ren	☐	$
E + Family	☐	$

Include coverage for the listed dependents. Unmarried children up to age 25 may be covered as a dependent.

Dependents	First, Middle Initial, Last Name	Social Security Number	Date of Birth	Male	Female
Spouse				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐

Do you or any dependents listed above have other dental insurance coverage? Yes ☐ No ☐

Membership in the DINA Dental Plan and dental insurance is requested for all persons named in this application. Please Note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to a fine and confinement in prison. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Applicant's Signature: _____ **Date Signed:** _____

Agent's Signature: _____ **DINA Agent #** _____

Takeover: Yes ☐ No ☐ Prior Carrier & Expiration Date: _____

Premium Payment Mode (Select Only One) ~ Include 1st month's premium & bank draft or credit card form.
(Individuals must pay 6 months, 12 months, or monthly bank draft. Payroll deduction available for groups only.)

Monthly Options: (Bank Draft & Credit Card Only)	Bank Draft ☐	Credit Card ☐

Payroll Deduction:	Weekly ☐	Bi-Weekly ☐	Semi-Monthly ☐	Monthly ☐

Other Options:	Quarterly ☐	Semi-Annually ☐	Annually ☐

Company Use Only

Group #	Dentist #	Dentist's Name:	Certificate #
Mode Premium $	Monthly Premium $	Amount Paid with App $	

DINA Dental Plan™
Guaranty Assurance Company
11969 Bricksome Ave, Ste A
Baton Rouge, LA 70816

DINA Dental Plan™
Customer Service: (866) 436-3093
Marketing: (800) 376-3462
Marketing Fax: (225) 292-3075

Application/Change Form for Membership and Dental Insurance

PPO Plan Application for Membership & Dental Insurance

Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip:
Phone:	SSN:	Date of Birth: Male ☐ Female ☐
Date of Hire:	Date of Termination (if cancelling):	

☐ Add ☐ Delete ☐ Change ☐ Cancel ☐ Other

Effective Date:
Notes:

Enrollment Status	PPO PLAN
Employee Only	☐ $20.00
Employee + One	☐ $38.00
Employee + Family	☐ $60.00

Include coverage for the listed dependents. Unmarried children up to age 26 may be covered as a dependent.

Dependents	First, Middle Initial, Last Name	Social Security Number	Date of Birth	Male	Female
Spouse				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐

Do you or any dependents listed above have other dental insurance coverage? Yes ☐ No ☐

Membership in the DINA Dental Plan and dental insurance is requested for all persons named in this application. Please Note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to a fine and confinement in prison. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Applicant's Signature: _____ **Date Signed:** _____

Agent's Signature: _____ **DINA Agent #** _____

Takeover: Yes ☐ No ☐ Prior Carrier & Expiration Date: _____

Premium Payment Mode (Select Only One)

Monthly Options: (Bank Draft & Credit Card Only)	Bank Draft ☐	Credit Card ☐			Other Options:		
Payroll Deduction:	Weekly ☐	Bi-Weekly ☐	Semi-Monthly ☐	Monthly ☐	Quarterly ☐	Semi-Annually ☐	Annually ☐

Company Use Only

Group #	Dentist #	Dentist's Name:	Certificate #
Mode Premium $	Monthly Premium $	Amount Paid with App $	

DINA Dental Plan™
Guaranty Assurance Company
11969 Bricksome Ave, Ste A
Baton Rouge, LA 70816

DINA Dental Plan™
Customer Service: (866) 436-3093
Marketing: (800) 376-3462
Marketing Fax: (225) 292-3075

Prepaid Plan Application for Membership and Dental Insurance

Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip:
Phone: / SSN:	Date of Birth:	Male ☐ Female ☐
Employer:	Work Phone:	
Date of Hire:	Date of Termination (if cancelling):	

Effective Date: _____ **Notes:** _____

Individual Prepaid Plan / Rates		**Group Prepaid Plan / Rates**	
Individual Only	$13.00	Employee Only	$13.00
Individual + 1	$21.00	Employee + 1	$21.00
Individual + 2 or 3	$28.00	Employee + Family	$28.00
Individual + 4 or More	$32.00		

Name of Selected Dentist Using the DINA Dental Network of Providers

Include coverage for the listed dependents. Unmarried children up to age 25 may be covered as a dependent.

Dependents	First, Middle Initial, Last Name	Social Security Number	Date of Birth	Male	Female
Spouse				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐
▪ Child				☐	☐

Do you or any dependents listed above have other dental insurance coverage? Yes ☐ No ☐

Membership in the DINA Dental Prepaid Plan is requested for all persons named in this application. Please Note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to a fine and confinement in prison. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Applicant's Signature: _____ **Date Signed:** _____
Agent's Signature: _____ **DINA Agent #** _____

Takeover: Yes ☐ No ☐ Prior Carrier & Expiration Date: _____

Premium Payment Mode (Select Only One)
(Individuals must pay 6 months, 12 months, or monthly bank draft. Payroll deduction available for groups only.)

Monthly Options: (Bank Draft & Credit Card Only)	Bank Draft ☐	Credit Card ☐			Other Options:		
Payroll Deduction:	Weekly ☐	Bi-Weekly ☐	Semi-Monthly ☐	Monthly ☐	Quarterly ☐	Semi-Annually ☐	Annually ☐

Company Use Only

Group #	Dentist #	Dentist's Name:	Certificate #
Mode Premium $	Monthly Premium $	Amount Paid with App $	

SINGLE CASE COMMISSION AGREEMENT

Group Name: _____ Group #:_____

Group Effective Date: _____

Agent Name: _____

Agent #: _____ Commission Payment: _____%

Agent Signature: _____ Date: _____

General Agent Name_____

Agent #: _____ Commission Payment: _____%

General Agent Signature: _____ Date: _____

Internal Sales Representative Name & #: Doug Jones #05

Sales Representative Signature: _____ Date: _____

Marketed and Administered by: DINA DENTAL PLANS

Underwritten By: GUARANTY ASSURANCE COMPANY

DINA Dental Plans

Credit Card Payment Form

Mail to: DINA Dental Plans
Attn: Accounting
101 Parklane Blvd, Ste 301
Sugar Land, TX 77478
Phone (866) 436-3093

Send this completed form and your application to:
Fax (832) 415-0131
E-mail: dina@fcldental.com

Card Description: **VISA** **MASTER CARD** **DISCOVER** **AMERICAN EXPRESS**
(Circle One)

Date: _____

Amount: _____

Card Number: _____

Exp. Date: _____

Customer ID Number:
(last 4 digits of SS# if new app) _____

Full Name on Card: _____

I hereby authorize DINA Dental Plans to process the above credit card and payment amount:

Signature: _____ Date: _____

Authorization to Honor ACH Drawn By Guaranty Assurance Company (DINA Dental)

Name of Depositor as Shown on Bank Records (Please Print)	Account Number

Name of Bank (Include Branch Name If Any)

Address of Bank or Branch (City and State)

As a convenience to me, I hereby request and authorize you to pay and charge to my account ACH drawn on my account by and payable to the order of Guaranty Assurance Company, Sugar Land, TX; provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such ACH shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until you actually receive such notice. I agree that you shall be fully protected in honoring any such ACH.

I further agree that if any such ACH be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date	Signature of Depositor as Shown on Bank Records

BDA - Guaranty Assurance Company, 101 Parklane Blvd, Ste 301, Sugar Land, TX 77478

Policy # (For Home Office Use Only	Print Name of Depositor as it Appears on Bank Records

Full Name of Bank (Include Branch Name If Any)

Address of Bank or Branch (City and State)

Routing Number (9 digits usually at far left of check)	**Account Number (10 digits)**

Automatic Bank Draft Authorization

I, the undersigned hereby authorize Guaranty Assurance Company, Sugar Land, TX, to draw ACH each month against my checking account at the Bank named above to pay my Dental Insurance Premium, and I agree that the presentation of such premium payment ACH shall constitute notices of insurance premiums due. I understand that this draft will take place on or around the 6th of each month until I discontinue my coverage with written notification.

Date Completed

Signature of Depositor as it Appears on Bank Records

***** Please Attach a Copy of a Voided Check *****
And send this form along with your application to:
dina@fcldental.com or Fax: (832) 415-0131

DINA Dental Plan™
Guaranty Assurance Company
101 Parklane Blvd, Ste 301
Sugar Land, TX 77478

DINA Dental Plan™
Customer Service: 866-436-3093
Email: dina@fcldental.com
~or~ Fax: 832-415-0131

DINA Dental Plan ~ Change Form

Member Information

(Fill in this section to make any changes, additions or deletions, then fill in the sections below accordingly)

(Member Name) _____ (Member Number) _____

(Address) _____

(City) _____ (State) _____ (Zip Code) _____

NAME OF GROUP _____ GROUP # _____

Change of Information

(Complete only the blanks for information with changes)

(Name Change) _____ (Member Number) _____

(Address Change) _____

(Any Other Changes) _____

Add Dependent(s)

Name (First, Last)	Date of Birth	SSN	Relationship to Member	Effective Date

Termination of Coverage

Cancel All Coverage ☐ Cancel Coverage for Listed Dependent(s) Only ☐

Name (First, Last)	Date of Termination

GUARANTY ASSURANCE COMPANY d/b/a DINA Dental Plan
A LIFE, ACCIDENT AND HEALTH INSURER
11969 Bricksome Avenue, Ste A
Baton Rouge, Louisiana 70816

AGENT APPLICATION ~ Please Mail, Fax, or E-mail

Last Name:	**First Name:**	**Middle Name (Initial):**

Agency Name (If Applicable):

☐ **Please check box to issue appointment under agency's name.**

Street Address:

City:	**State:**	**Zip:**

Phone Number:	**Fax Number:**	**Cell Number:**	**E-mail:**

Agent/Agency Tax ID Number:	**Agent/Agency License Number**

The undersigned agent warrants and represents that his or her class "C" license has not been suspended, revoked, or restricted, by any court, or agency of competent jurisdiction within any state during the past five years, and that said class "C" license is also in good standing with the Department of Insurance of the issuing state for its current license year.

Agent's Signature **Date**

A check payable to Guaranty Assurance Company for the initial appointment fee of $20.00 is required before Guaranty Assurance Company will process a new agent's application. Please also complete and return a W-9 Form with your Agent Application.

Company Use Only

Agent Master	Agent Number	Agreement Percentage
Field 0		
Field 1		
Field 2		
Field 3		
Field 4		

Approved By:	Date:	Master Updated By:	Date:

Agent Number

Contract Date:	Fee Paid: ☐ Yes ☐ No

DINA Dental Plan™

Fax (225) 292-3075 ~ E-mail: loralyn@dinadental.com

Toll Free: (800) 376-3462 ~ Local (225) 291-3172 x1401

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Exempt payee

☐ Other (see instructions) ▶

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/ disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/ disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

DINA Dental Plan™

HIPAA BUSINESS ASSOCIATE AGREEMENT

IN COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into by and between **Guaranty Assurance Company, d/b/a DINA Dental Plan** ("DINA" or "Covered Entity") on behalf of itself, and its current and future subsidiaries and affiliates, and _____ ("Business Associate"), including all current and future lines of business, affiliates and subsidiaries. Covered Entity and Business Associate may have entered into various arrangements, and may in the future enter into additional arrangements (collectively, the "Contracts") pursuant to which Business Associate provides various items or services to Covered Entity. This Agreement modifies and supplements the terms and conditions of the Contracts, and the provisions set forth herein shall be deemed a part of the Contract(s). This Agreement is effective upon execution, and submission by the Business Associate to Covered Entity.

Covered Entity and Business Associate mutually agree to the terms of this Agreement to comply with the requirements of the Standards for Security and Privacy of Individually Identifiable Information (the "Security and Privacy Regulations"), as applicable, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, as well as with the Health Information Technology for Economic & Clinical Health Act ("HITECH"), Subtitle D-Privacy (§§13400-13424), as part of the American Recovery and Reinvestment Act of 2009, as amended.

Effect. This BA Agreement amends, restates and replaces in its entirety any prior business associate agreement between the parties. This BA Agreement supersedes all prior or contemporaneous written or oral contracts or understandings between FCL Dental and Agent relating to their compliance with health information confidentiality laws and regulations, including HIPAA and HITECH. Business Associate and Covered Entity have a business relationship such that Covered Entity may be deemed to be a covered entity, and in conducting such activities on behalf of Covered Entity, Business Associate may be deemed a business associate of Covered Entity. Covered Entity wishes to disclose certain information to Business Associate pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI") (as defined below).

Purpose. Protected Health Information. The purpose of this Agreement is to provide assurances regarding Covered Entity responsibilities to maintain strict confidentiality under applicable federal and state laws and regulations relating to our member's medical information, financial information, and other patient identifiable health information to which Business Associate gains access pursuant to the Contracts (collectively "Protected Health Information"). For purposes of this Agreement, Protected Health Information shall be defined consistent with 45 CFR, Section 164.501. The provisions of this Agreement are specifically intended to meet the business associate contract requirements of the HIPAA privacy standards spelled out in Section 45 CFR, Section 164.504.

Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to this Agreement in compliance with the HIPAA Security and Privacy Regulations and HITECH.

HIPAA Security and Privacy Regulations and HITECH require Covered Entity to enter into a contract containing specific requirements with Business Associate prior to the disclosure of PHI, as set forth in this Agreement.

A. *Definitions*

1. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.
2. Breach "Breach" has the meaning given in 45 CFR § 164.402.
3. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to the party to this agreement, shall mean The Medical Protective Company.
4. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103.
5. Designated Record Set. "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.
6. HIPAA "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing rules and regulations, including the HIPAA Breach Notification Rule, the HIPAA Privacy Rule, and the HIPAA Security Rule.
7. HIPAA Rules."HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and "HIPAA Breach Notification Rule" means the Breach Notification for Unsecured Protected Health Information issued by HHS, 45 CFR Parts 160 and 164 (Subparts A and D).
8. HIPAA Omnibus Rule "HIPAA Omnibus Rule" means the Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule issued by HHS, 45 CFR Parts 160 and 164.
9. HIPAA Privacy Rule "HIPAA Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information regulations issued by HHS, 45 CFR Parts 160 and 164 (Subparts A and E).
10. HIPAA Security Rule "HIPAA Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information issued by HHS, 45 CFR Parts 160 and 164 (Subparts A and C).
11. HITECH "HITECH" means the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A of the American Recovery and Reinvestment Act of 2009 and its implementing regulations.
12. PHI "PHI" or "Protected Health Information" and "Electronic PHI" have the respective meanings given in 45 CFR § 160.103, except that each is limited to PHI (and Electronic PHI) that Business Associate creates, receives, maintains, transmits or collects for or on behalf of Covered Entity, and meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
13. Required by Law "Required by Law" has the meaning given in 45 CFR § 164.103.
14. Subcontractor "Subcontractor" has the meaning given in 45 CFR § 160.103.
15. Unsecured PHI "Unsecured PHI" has the meaning given in 45 CFR § 164.402.

B. ***Obligations and Activities of Business Associate***

Business Associate agrees to:

1. Business Associate agrees to fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose Protected Health Information other than as permitted or required by this Agreement, Service Contracts, or as Required by Law. In case of any conflict between this Agreement and Service Contracts, this Agreement shall govern;
2. Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law and to Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of Protected Health Information to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule;
3. Use appropriate procedural, physical, and electronic safeguards, and comply with Subpart C of 45 CFR Part 164, to prevent use or disclosure of Protected Health Information other than as provided for in this Agreement. Said safeguards shall include, but are not limited to, requiring employees to agree to use or disclose Protected Health Information only as permitted or required by this Agreement and taking related disciplinary actions for inappropriate use or disclosure as necessary;
4. Report to Covered Entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;
5. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, require any agent, including a subcontractor, to whom it provides Protected Health Information received from, created or received by, Business Associate on behalf of Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to Protected Health Information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information;
6. Require its employees, agents, and subcontractors to immediately report, to Business Associate, any use or disclosure of Protected Health Information in violation of this Agreement and to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement;
7. Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement;
8. If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to provide access, at the request of Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least FIVE (5) days from Covered Entity notice to provide access to, or deliver such information;
9. If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to make any amendments to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the

time and manner designated by Covered Entity, provided that Business Associate shall have at least FIFTEEN (15) days from Covered Entity notice to make an amendment;

10. Document disclosures of Protected Health Information and information related to such disclosures as would be required for covered Entity to respond to a request by an Individual for an accounting of disclosure of Protected Health Information in accordance with 45 CFR § 164.528;
11. To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s);
12. Business Associate agrees to make its internal practices, books, and records including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by or received by Business Associate on behalf of, Covered Entity available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Covered Entity or the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule;
13. Business Associate agrees to provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for and accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least FIFTEEN (15) days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the Protected Health Information was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure;
14. Business Associate agrees to adequately and properly maintain all Protected Health Information received from, or created or received on behalf of, Covered Entity, document subsequent uses and disclosures of such information by Business Associate as may be deemed necessary and appropriate by the Covered Entity, and provide Covered Entity with reasonable access to examine and copy such records and documents during normal business hours of Business Associate; and
15. If Business Associate receives a request from an individual for a copy of the individual's Protected Health Information, and the Protected Health Information is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual and notify the Covered Entity of such action. If Business Associate receives a request for Protected Health Information in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

C. *Permitted Uses and Disclosures by Business Associate*

1. Business Associate may only use or disclose protected health information as necessary to perform any services necessary or required as Covered Entity's insurance company.
2. Business Associate may use or disclose protected health information as required by law.
3. Business Associate agrees to make uses and disclosures and requests for protected health information subject to the following minimum necessary requirements: as necessary or required in order to provide Covered Entity's insurance.

4. Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity, except with regards to the data aggregation, management, administration and legal responsibilities of the Business Associate.
5. Business Associate may use protected health information for the Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.
6. Business Associate may disclose protected health information for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
7. Business Associate may provide data aggregation services relating to the health care operations of Covered Entity.

D. ***Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions***

Covered Entity shall notify Business Associate of:

1. any limitation(s) in Covered Entity's notice of privacy practices under 45 CFR 164.520;
2. of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information; or,
3. any restriction on the use or disclosure of protected health information that Covered Entity has agreed to or is required to abide by under 45 CFR 164.522,to the extent that Business Associate's use or disclosure of protected health information will be affected.

E. ***Term and Termination***

1. Term. This Agreement shall continue in force so long as any underlying contract between the Covered Entity and Business Associate remains in force.
2. Termination for Cause. The Covered Entity shall provide written notice if it determines that Business Associate has breached any material provision of this Agreement. The written notice must contain the facts necessary for Business Associate to evaluate and cure the alleged breach. If the breach is not cured within 30 days, the Covered Entity may immediately terminate this Agreement.
3. Obligations of Business Associate Upon Termination. Upon termination of this Agreement for any reason, Business Associate, with respect to protected health information received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:
    a. Retain only that protected health information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
    b. Destroy the remaining protected health information that Business Associate still maintains in any form;

c. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as Business Associate retains the protected health information;
d. Not use or disclose the protected health information retained by Business Associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at above which applied prior to termination; and
e. Destroy the protected health information retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

4. Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

F. ***Miscellaneous***

1. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.
2. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.
3. Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

IN WITNESS WHEREOF, the Covered Entity and the Business Associate execute this Business Associate Agreement to be effective as of the date signed and submitted by the Business Associate to Covered Entity as indicated below:

Business Associate	**Guaranty Assurance Company d/b/a DINA Dental Plan**
Print Business Name/Agent Name	Print Name
Signature	Signature
Broker/Owner Title	Vice-President Title
Date	Date